

**Casualties of War
Vietnam War Veterans PTSD and Depression**

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Thank you for asking me to speak to you tonight.

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Glossary of Terms

DSM	Diagnostic and Statistical Manual of Mental Disorders 4 th Edition (2000) - text revised
DVA	Department of Veterans Affairs
GHQ	General Health Questionnaire
KIA	Killed in action
LBJ	Lyndon Bains Johnson
PTSD	Post Traumatic Stress Disorder
VVCS	Vietnam Veterans Counselling Service
SSRI	Selective Serotonin Reuptake Inhibitors
WW	World War (1 st /2 nd)

Abstract

Vietnam Veterans are a unique group of war veterans who have a high incidence of psychiatric morbidity. Some of the reasons for this circumstance are suggested in this paper, along with the impact that such morbidity has had on both partners and families.

Post traumatic stress disorder (PTSD) is a primary diagnosis along with co-morbid conditions of alcohol abuse, anger and depression. PTSD is discussed as a paradigm and explained. The problem of depression, even if briefly, is also examined. The serious ongoing problems of mental health among the Veteran population is a major concern and the focus of this presentation.

1. Introduction

Vietnam veterans are a special group of war veterans for many reasons, which may explain some of the perceived differences between them and veterans from other wars.

The first myth I would like to dispel is the idea that Vietnam veterans have more psychopathology than other veterans of war do. In many respects this is quite unknowable. The ability we have today to record and manipulate data makes our understanding of more recent events easier than ever before. One analogy may be to suggest there is more child abuse than 60 years ago, when in all likelihood its in fact that reporting child abuse is more prevalent.

The second reason it may seem this way is that for some years now, Vietnam veterans are the “current generation”. They are often your parents age, the baby boomers, so the war and its sadness is still very much in our immediate memories, despite it being over some 30 years, this year.

The third reason that Vietnam veterans may have more problems than other veterans is that the voices of Vietnam veterans have been louder and more militant than probably any other group. Again, there are a number of reasons for this, which may become self evident in the next section. Incidentally I am not saying that Vietnam veterans don’t have higher incidences of psychiatric morbidity, rather that the issues are at least clouded by these factors

2. A very Brief History of the War

24 May 1962	Experts in Jungle warfare sent to Vietnam as “Advisers”.
29 April 1965	Robert Menzies commits Australian troops
November 1964	National Service Act
October 1965	First Battalion deployed
April 1966	The first battalion is deployed into Phuoc Toy Province
17 August 1966	Battle of Long Tan 17 Australians KIA, 31 wounded, VC 245 killed, 350 wounded
1967	TET Offensive involving 80,000 Viet Kong nearly half killed
16 March 1968	Mai Lai
8 November 1970	A battalion returned to Australia and not replaced
1970	Vietnamisation

2 December 1972	Gough Whitlam withdraws Australian troops
1901-1972	White Australia Policy ends
27 January 1973	Peace treaty signed
April 1973	Cease-fire

Australia – The Cost

50,190 served
15,542 conscripted (31%)
496 KIA
2,398 wounded
Australian psychiatric casualties estimated by VVCS at 20% (2003)

Other Casualties

1 million Viet Cong KIA
200,000 South Vietnamese KIA
56,555 US KIA
500,000 Vietnamese civilians killed

The end of the Vietnam War and the first socialist government in 1972, meant and reflected a change in moves and attitudes of Australian society. A “make love not war”, free love slogans and freethinking dominated the social fabric. War was simply an abhorrence, but that war in particular, which was seen as nothing more than us touting to the Americans “All the way with LBJ” or worse still, what about this, “I am gay for LBJ” (gay had then a totally inference). In fact, the demand for a moratorium on our involvement in the war was the beginning of the end. However, there was in one sense a down side to this ground swell of opinions. The war was not considered a real war by many, including the RSL, who initially denied Vietnam Veterans full membership, so not only did much of Australia, have little time for its combatants, even conservatives took them as being less than legitimate.

In many welcome home parades, it wasn't unusual, (when they actually happened) for them to be jeered not cheered, and often spat upon. This lack of affection of troops left many Veterans feeling isolated, betrayed and even worse. I will suggest to you later in this presentation that this lack of affection may have had a profound impact on their psychiatric morbidity.

Vietnam also saw a large contingent of conscripts who were just 19 or 20 years of age. Too young? Yes, many people thought so but it is always that age-group who have always taken the brunt of front line combat in any war. Just children who see themselves as “invincible” even “bullet proof”. Incidentally, it was the

conscript issue that saw the voting age reduced from 21 to 18 years. Most thought it wasn't proper to have someone fighting for democracy but didn't have the right to vote.

There were several other issues that made our troops engaged in that war perhaps different from other campaigners. I will touch on just a few points. The first was the difference in the socialisation process, between my father (your grandfathers) and myself. My father was born in a time where wars had been part of life forever, the Crimean, the Boar, and the Second World War. He also lived through a depression. His father, like many, was tough and schools were places where corporal punishment was readily dished out and accepted. On the other hand my generation lived in a time of plenty, while the Korean war had occurred, it wasn't a war with the magnitude of WWI or WWII. I believe that we were not as psychologically hardy as our forebears. I think psychological hardiness and resilience are important factors in determining mental health following traumatic circumstances. Importantly WWII, was and has always been considered a just or justifiable war, do you see the contrast between that and Vietnam? That was considered unjust. You will note later when I discuss the question of "trauma", one qualification for an incident to be traumatic is that it must be "unjust". I will pick this theme up later when discussing the notion of PTSD. The war came when never before had we enjoyed such a high standard of living. The central purpose of our lives in the 60's was no longer just work and survival, but having a good time, a quite different preparation for a war!

The second point, (and I only want to perhaps make these two), was the absence of a formal or even informal demobilisation process at the end of the war or tour of duty. My father, after WWII was like his peers, "demobbed", as it was called over months, he also spent time on a ship returning home, sharing his story with others. Vietnam Veterans on the other hand were in the field of battle one day and the next day home. This was especially true for conscripts who after arriving home a few days later, were back on "civvy street", as it was called. Many of these soldiers often never having the opportunity of telling their story, just shoving it into an emotional kitbag and getting on with life.

3. PTSD – putting the paradigm in context

I want to now move more directly from the historical perspective in respect to Vietnam Veterans to their health in particular Posttraumatic Stress Disorder (PTSD). This should not be confused with war neurosis, especially battle fatigue, even though they are often treated as being synonymous. In fact battle fatigue occurs generally while on operational duty or immediately afterwards, as does "shellshock", a term used in WWI. PTSD can be delayed often months weeks or even years after combat. Robinson (2000) from the Mayo Clinic in Taree cites cases of PTSD occurring even 40 years or more after the end of war, quoting the case of a sailor who suffered delayed PTSD some 50 years after WWII, simply triggered by the sinking of the Russian submarine Korsk. I had another patient, a Vietnam veteran who was hospitalised after simply seeing the television report of the fire aboard the HMAS Westralia, you may recall that just a couple of years ago.

In fact an interesting finding has been that immediate psychiatric casualties at the time of the Vietnam War were less than any other war, but the estimated delayed psychiatric casualties were the highest of any war. The reason given is that the period of actual combat was short i.e. less than 12 months and troops were rested for some weeks by way of rest and recreation mid tour of duty. In short battle fatigue was avoided.

You may note that I quoted psychiatric referrals earlier as being quoted by the VVCS to me at 20%. I have left that figure in the overhead because I think it shows a lack of clear information in this regard. I was for instance unable to obtain from VVCS or DVA, the actual psychiatric morbidity rates comparing conscripts with regulars. It's hard to even determine the actual statistics in respect to Vietnam veteran's health. Although a major health study in 1998-1999 by the DVA indicated that the psychological morbidity of veterans is three times the national average. This was based on veteran self-report. Now we know that the average psychiatric morbidity among the Australian population is in fact 20%, thus an estimate of 60% morbidity of those who served is probably accurate. Further inquiry with the VVCS indicated that as many as 70% of veterans have had contact with their offices, which I think again validates this estimate. There was also a validation study, which established that the 1998-1999 studies were valid and there was no significant bias in reporting, a problem that so besets studies that use self report as the basis for gathering data.

This 60-70% is a stunning statistic and shows that while we lost just a few less than .5 of one percent KIA; the facts are that the human cost in terms of psychiatric casualties was quite phenomenal. One counter argument has been that many veterans have since accessed counselling and suffered from conditions because of the attractiveness of the DVA pension. [Joke here].

In fact there is a considerable amount of cynicism among many who work with veterans, which undoubtedly clouds and causes some resentment by those that are employed to assist veterans and their families. I want to return to families a little later. There is however some research that would indicate that the morbidity among veterans for those who seek pensions and those that do not is *not* significant. This suggests that while the variable of gaining a pension may be one motivation, it does not account or explain the full extent of morbidity found among Vietnam veterans.

Of course for those that have psychiatric/psychological conditions, I have found a great deal of attribution occurs in their beliefs about themselves. This is in part because, as the earlier joke indicates, there is for many veterans focus on "sickness", rather than wellness. Indeed that is how we as a community respond to these veterans. Attribution, also leads to the often mistaken belief that because a condition is generated by war, then all other conditions that follow are solely the result of that war. For instance alcohol abuse is an often-found co-morbid condition of PTSD. But rather than work on managing the problem of abuse, it is too often simply attributed to PTSD. As such many claim as they are powerless to resolve their PTSD, they are thus powerless to resolve their problem of alcohol abuse. In this way the co-morbid condition remains problematic. Another is the frequently found problem of uncontrolled anger

among veterans. This claimed inability to stop behaviour is akin to saying that because someone is an alcoholic they have to drink. When in the reality it is more accurate to say that the person chooses to drink, they can stop, but because of the condition it's simply harder. In our Lifestyle courses this sense of ownership, accountability and personal responsibility are major themes as we try to assist veterans move from this sickness (helpless) to wellness (empowered) model of behaviour.

I mentioned families of Vietnam Veterans before and I want to refer to a field study (Peters and Peters 2000). Which examined a phenomenon identified by Westerink and Giarratano (1999). This study found that the partners of Vietnam Veterans mimicked the General Health of Veterans. I will just report their findings in respect to the General Health Questionnaire.

Table 1

	Veteran's Partners Scores	Control Group Scores
GHQ total	9.97	1.47
Somatic Symptoms	2.5	0.60
Anxiety and Insomnia	3.7	0.27
Social dysfunction	2.6	0.53
Severe depression	1.19	0.01

The GHQ or General Health Questionnaire is an intake assessment and the maximum score is "28" and the minimum "0" As you can see the general population the scores are very low by comparison. We were interested to see whether this could be replicated but also if the two correlated. Westerink et al (1999) study included other measures and was principally interested in the outcome for partner's GHQ scores compared to the general population. However our field study that incidentally had triple the number of subjects, not only replicated their results, but also showed the direct relationship between partners scores as indicated in the following table. This has been referred to as "folie au deux (the silliness or insanity of two).

Table 2

Mean of Scores of Total Lifestyle Group

Factor	Mean (Partners)	Mean (Veterans)
Total GHQ	6.32	9.825
Somatic Symptoms	2.00	2.43
Anxiety and Insomnia	2.25	2.625
Social Dysfunction	1.7	3.075
Severe Depression	1.275	1.375

These scores I think you will agree show that the casualties of war are never just limited to the combatants. In the major study by DVA mentioned earlier as an extension to that study they examined veteran's children. That study found that children of veterans likewise were found to have higher psychiatric (not physical) morbidity compared to children from the general population. For instance children of veterans have three times the rate of suicide than other children. In fact the average number of suicides for children on average from 1988-1996, was 14.8 for the general population, whereas the number for children of veterans was 46.6 per year. There is a similar outcome in respect to "trouble with the law".

Again I apologise if this has been a rather convoluted journey to arrive at discussing PTSD and the frequently found co-morbid condition of depression. However I think the historical and sociological understanding is important, so too an understanding of the dimension and magnitude of the problem I think is essential if the mental health of veterans is to be put in it's full context.

4. Trauma

I suggest in my book "Managing the Impact of Trauma (2000), there are three conditions or pillars that make an incident traumatic. a) It must be life threatening to one-self or others, b) it must be unjust, (do you recall the notion of justice in respect to war in my introduction?) and c) it must expose our vulnerability. I also have been moved over the years to include not just physically life threatening events, but also ego threatening events such as bullying. People who have been bullied or victims of psychological abuse such as domestic violence, often present as if traumatised.

5. PTSD Explained (briefly)

Like trauma PTSD has three pillars, but first its important to realise that PTSD is a paradigm or model in which we examine a collection of symptoms, it is not a disease or illness such as schizophrenia. Thus, it's also important to understand that the normal idea of "cure" doesn't make sense, but management of the disorder is possible. That's what we attempt in therapy – management.

The three pillars are that a) the person must suffer from distressing intrusive thoughts or flashbacks of the event(s) and or experience nightmares of the event(s) or similar themes of horror. b) They must be hypervigilant or hyper aroused, suffering from an anxiety, c) they experience avoidance, of being involved not with just those events that were traumatic and further exposure, but often anything involving conflict. Aside from psychological and physical symptoms, these symptoms impair concentration and cause adverse behavioural outcomes. However the major cause of co-morbid conditions is the excessive level of anxiety, this is particularly the cause in respect to depression.

6. Depression

I do not have the time to discuss the various types of depression to any extent, but I think it is important to understand there are a number of types of depression. The first is by way of personality. Theodore Millon referred to a

depressive personality disorder, which is more than simple melancholia, which features dysphoric mood (an absence of joy). A personality on the other hand is more than disposition but a disorder interferes with every aspect of functioning.

A second type of depression is manic depression, or clinically referred to as “bipolar disorder” which is probably chemically based more than anything else, thus the primary treatment of the condition is by way of chemistry (Lithium Carbonate).

A third and the most prevalent is reactive depression, which is what I regard as a normal response to abnormal and distressing events. An example may be bereavement. A fourth is when there has been a long period of stress or anxiety and a resultant depression, I often refer to this as learning to become depressed and there are of course bio-chemical implications. Endogenous or clinical depression may occur for a number of reasons (see DSMIV Major Depression). For instance, it can occur because of a long history of reactive depressed mood, distress or anxiety. The intimate connection with anxiety is obviously and one reason why so many veterans develop depression. However depression may occur due to genetic, hormonal influences (e.g. Post Natal Depression). In this group there are also those who suffer endogenous depression, simply for no apparent reason at all. For instance Gerry Halliwell, one of the Spice Girls, experienced this commenting in her book, “how could I, with all I have suffer depression?”

My own opinion is that many suffer and develop depression due to more existential, dare I say spiritual reasons, seeing little purpose in their lives and so often no connectivity with their spirituality. Its interesting to note that depression in Australia is keeping pace with our GDP, i.e. with increases in riches there are corresponding increases in depression.

However, I digress, those with traumatic stress or anxiety seem to be many times more prone to depression and as I said the most frequent condition suffered by Vietnam Veterans, pathological anger and alcohol abuse being the other two most often found co-morbid conditions. If I have the opportunity I would like to explain how in fact military training can pre-dispose soldiers to PTSD! Again to repeat myself, all depression emanates from anxiety and thus with anxiety being a primary symptom of PTSD it should be little wonder how depression occurs.

Treatment should ideally be two fold, aside from dealing with the symptoms and problems associated with PTSD, depression responds well to cognitive behavioural techniques and medication. The primary medication used these days has moved away from the tricyclics (we actually gave suicidal people a medication that could kill them!) to today what are referred to as the selective serotonin re-uptake inhibitors, (SSRI) most of you may have heard of one of the original brands i.e, Prozac.

It is thought that Serotonin is the “lock” that opens the pathway to reverse the adverse affects of depression, my extension to this analogy is that may be true and serotonin is the “lock” but we still have to find the right key for everyone. I

must say though that SSRI treatment is normally productive and most of my clients make substantial gains when medicated.

7. Conclusion

Returning to Veterans there is no doubt in my mind that few veterans have PTSD caused by one simple traumatic event. It's mostly a constellation of events and traumatic experiences. I would like to have the opportunity to discuss some of the reasons why some are traumatised by an event and others not. One caution I can offer, is that you only use "gruesomeness" as just one factor in why a person may be traumatised. It is interesting that current research suggests that the chances of suffering PTSD are increased by 300% in a non--supportive environment. Now think back to my comments at the beginning of this paper when I discussed the lack of affection, welcome and assistance for these soldiers on their return from war. (See picture). Thus I think there are many war but importantly non-war events that has caused such excessive levels of morbidity among Vietnam Veterans.

I realise that I have probably stopped short of giving a full and extensive account of this subject but perhaps you have some questions, which I am happy to answer.